Virginia Employee Enrollment/Change Form (1 - 50 Employees)

Aetna Life Insurance Company, Aetna Health Inc.

Life, Accidental Death & Personal Loss Coverage (AD&D Ultra®), Disability, Aetna Vision℠ Preferred plans, Aetna Preferred Provider Organization (PPO), Aetna PPO Health Savings Account (HSA) Compatible and Aetna Indemnity plans are underwritten by **Aetna Life Insurance Company**. Aetna HMO and Aetna Health Network Only plans are underwritten by **Aetna Health Inc**. Aetna DNO* and Dental Preferred Provider Organization (PPO) plans are underwritten by **Aetna Life Insurance Company**. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

*DNO (Dental Network Only) in Virginia is not an HMO. To receive maximum benefits, members must choose a participating primary dentist to coordinate their care with in-network providers.

INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If enrolling, please be sure to sign and date Employee Signature on Page 5. If waiving coverage, please complete Section B.** Please use only black ink to complete this form.

Member Aetna ID Number (if available)

Company Name: People Solutions

Effective Date	☐ New Hire	☐ Add Spouse	☐ Employee Termination
	☐ Rehire/Reinstatement*	☐ Add Domestic Partner	☐ Remove Spouse
Date of Hire	☐ New Group Enrollment	☐ Add Dependent Child	☐ Remove Domestic Partner
	☐ Late Enrollment	☐ Change of Coverage	☐ Remove Dependent Child
	☐ Waiver	☐ Name Change	☐ Cancel Coverage
Benefit Waiting Period* ☐ Class 1 ☐ Class 2 *only required when your employer has 2 benefit waiting periods	☐ Open Enrollment * Does not apply to Supplemental or Dependent Life Insurance		☐ Other ________

☐ **COBRA** ☐ **Continuation for:** ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 months ☐ 36 months ☐ Other ______
Qualifying Event ____________ Original Qualifying Event Date ________ Loss of Coverage Date ________

A. Employee Information – *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.		Job Title
Home Address	Apt. No.	City, State	ZIP Code
Work Address		City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	Primary Language Spoken (Optional)	Number of Dependents including Spouse or Domestic Partner enrolling for coverage
Salary (if Life coverage is elected) $ ______ ☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One: ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Union ☐ COBRA ☐ Seasonal ☐ Temporary	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

B. Declination/Waiver of Coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ **Employee:**
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision
- ☐ STD ☐ LTD
- ☐ Life & Disability Packaged Plan

☐ **Spouse:**
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision

☐ **Child(ren):**
- ☐ Medical ☐ Dental
- ☐ Life/AD&D Ultra® ☐ Vision

Reason for declining coverage
- ☐ Spouse group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ I have no other coverage
- ☐ Other ____________

I certify I have been given the right to apply for this coverage; however, I am waiving coverage as noted above. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s). X **Employee Signature**	***Date (Month/Day/Year)***

Please PRINT employee name:

C. Coverage Selection *(Shaded sections for Employer/Aetna Use Only)*

Control/Group No. 93524612	Suffix	Account	Plan No.	Class Code

1. Medical
- ☐ **VA HMO** – Plan Option: ____________
- ☐ **VA Health Network Only** – Plan Option: ____________
- ☐ **VA Health Network Only – HSA Compatible** – Plan Option: ____________
- ☐ **VA PPO** – Plan Option: ____________
- ☐ **VA PPO HSA Compatible** – Plan Option: ____________
- ☐ **VA Indemnity** – Plan Option: ____________

Control/Group No.	Suffix	Account	Plan No.	Class Code

2. Dental – *To enroll, enter plan number and name elected below.*

Contributory Plan:
Plan Number: ____________
Plan Name: ____________
If FOC, check: ☐ DNO *or* ☐ PPO

Voluntary Plan:
Plan Number: ____________
Plan Name: ____________
If FOC, check: ☐ DNO *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☒ No

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary Plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Control/Group No.	Suffix	Account	Plan No.

3. Vision (if applicable)
Aetna Vision Preferred ☐ Yes ☒ No *Check applicable box.*

Control/Group No.	Suffix	Account	Plan No.

4. Life and Disability ☐ Yes ☐ No

Life/AD&D Ultra® (for groups with 2-9 employees) *Check applicable boxes.*
- ☐ **Employee** Basic Life/AD&D Ultra®

Life/AD&D Ultra® (for groups with 10-50 employees) *Check applicable boxes.*
- ☐ **Employee** ☐ Basic Life/AD&D Ultra® ☐ Supplemental Life/AD&D Ultra®
- ☐ **Spouse** ☐ Optional Spouse Life/AD&D Ultra®
- ☐ **Child** ☐ Optional Child Life/AD&D Ultra®

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C. Coverage Selection *(Continued)*

DESIGNATION OF BENEFICIARY – Carefully review Additional Conditions and Instructions for Designation of Beneficiary on Page 6.
The Group Policy grants the member the authority to designate a beneficiary. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary(ies) predeceases the insured or is otherwise barred by a state law and/or a legally binding document addressing benefit payments. The employee is automatically the primary beneficiary for dependent life and accidental death and personal loss coverage (AD&D Ultra®) benefits.

Beneficiary For:	Full Name(s) or Entity (Trust or Estate)	Date of Birth	Social Security Number / Tax ID Number	Address (Number, Street, Apt. No., City, State, ZIP Code)	Phone	Relationship to Employee	% of Benefit (must equal 100%)
Basic Life/ AD&D Ultra® Primary							
Basic Life/ AD&D Ultra® Contingent							
Supplemental Life/AD&D Ultra® Primary							
Supplemental Life/AD&D Ultra® Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY – See Additional Conditions and Instructions for Designation of Beneficiary Section on Page 6.

Please note that an Employee is under no obligation to complete the Spousal Consent section on this form.

I am aware that my spouse, the Employee named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature ______________________________ **Date** ____________

Disability (*Coverage for* ***Employee*** *only*) *Check applicable boxes.*

Short Term Disability (for groups with 2-50 employees) ☐ Yes ☐ No
Long Term Disability (for groups with 10-50 employees) ☐ Yes ☐ No
Life and Disability Packaged Plan (for groups with 2-50 employees) ☐ Yes ☐ No

D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.* NOTE FOR MEDICAL COVERAGE:

While the Federal Patient Protection and Affordable Care Act mandates coverage of children up to age 26, your plan may allow coverage to age 26 and beyond for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

1	(A)dd (C)hange ___ (R)emove	**Employee Name** (Last, First, M.I.)	Sex (M/F)	Birthdate (MM/DD/YYYY) / /

Coverage Election	If choosing HMO, Primary Office ID #	Current Patient	If choosing DNO, Primary Office ID #	Current Patient
☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision ☐ STD ☐ LTD ☐ Life & Disability Packaged Plan		**Yes** ☐		**Yes** ☐

2	(A)dd (C)hange ___ (R)emove	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner**	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY) / /

Coverage Election	If choosing HMO, Primary Office ID #	Current Patient	If choosing DNO, Primary Office ID #	Current Patient
☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		**Yes** ☐		**Yes** ☐

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D. Individuals Covered *(Continued)*

#	(A)dd / (C)hange / (R)emove	Name (Last, First, M.I.) ☐ Child ☐ Stepchild ☐ Other	Sex (M/F)	Social Security Number	Birthdate (MM/DD/YYYY)
3	(A)dd (C)hange ___ (R)emove				/ /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DNO, Primary Office ID # / Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No
4	(A)dd (C)hange ___ (R)emove				/ /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DNO, Primary Office ID # / Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No
5	(A)dd (C)hange ___ (R)emove				/ /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DNO, Primary Office ID # / Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No
6	(A)dd (C)hange ___ (R)emove				/ /
Coverage Election ☐ Medical ☐ Dental ☐ Life/AD&D Ultra® ☐ Vision		If choosing HMO, Primary Office ID #	Current Patient Yes ☐	If choosing DNO, Primary Office ID # / Current Patient Yes ☐	Incapacitated ☐ Yes ☐ No

E. Dependent Information

List any dependent in Section **D** living at another address.

Name	Address

F. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If Yes, will Aetna coverage being applied for replace your current in-force coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

Conditions of Enrollment

On behalf of myself and the dependents listed, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - HMO and Health Network Only Plans: Aetna Health Inc.
   - PPO and Indemnity Plans: Aetna Life Insurance Company
   - Dental Plans: Aetna Life Insurance Company
   - Aetna Vision plans: Aetna Life Insurance Company; certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").
   - Life, Accidental Death & Personal Loss Coverage (AD&D Ultra®), disability and all other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer application have been accepted and approved by Aetna. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

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Conditions of Enrollment *(Continued)*

For life coverage: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being active at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependents are eligible from birth up to their 26th birthday.

For disability coverage: I understand that the effective date of my insurance is subject to my being active at work on that date. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.

3. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies and/or pharmacy database benefit managers, to give to the Aetna company(ies) underwriting coverage(s) for the product(s) checked in the Coverage Selection section on Page 2, or its (their) agent(s), information concerning the medical history, services or treatment provided to anyone listed on this Application, including those involving mental health, substance use disorder and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization is applicable to the Aetna company(ies) underwriting coverage(s) for the product(s) checked in Section C on Page 2. I have discussed the terms of this authorization with my spouse or domestic partner and competent adult dependents, and I have obtained their consent to those terms. This authorization will remain valid for 30 months from the date I signed it or in the case of the information described above being collected in connection with a medical claim, this authorization will be valid for the term of the coverage. In the case of a life claim, the authorization will remain valid for the duration of the claim. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the plans described above.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery®, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DNO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

Authorization

7. I authorize deductions from my earnings for any contributions required for coverage, and I agree to make any necessary payments as required for coverage.
8. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

Misrepresentation

9. Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment, Authorizations and Misrepresentation on this Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my eligibility and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week for this employer at the regular place of business.

The undersigned subscriber, and agent, when an agent is involved in the enrollment of Basic Life Benefits Greater than the Guaranteed Issue Level, certify that the subscriber has read, or had read to him/her the completed enrollment form and that the subscriber realizes that any false statement or misrepresentation in the enrollment form may result in loss of coverage under the policy.

If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependent(s). ***Employee Signature*** X	***Date (Month/Day/Year)***
Employee E-mail Address	*In enrolling in an HMO/Health Network Only or DNO plan, I acknowledge that a PPO or dental PPO plan has been offered to me.* ☐ Yes ☐ No
Insurance Agent Signature X	***Date (Month/Day/Year)***